

Michael J. Abramsky, Ph.D.

DIPLOMATE AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY

Ryan Fishman. 4-30-21 Intake:

DOB: [REDACTED]

Mr. Fishman was referred by an x-patient.

Diagnosis is "adjustment disorder with Anxiety. There is no Axis II Diagnosis, no premorbid
psychopathology.

Michael F. Abramsky PhD, ABPP
Licensed Clinical Psychologist
Diplomate in Clinical Psychology.
Diplomate in Forensic Psychology

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File No. 81720

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
Main Only: Claims Service and Solutions Group
PO Box 981593, El Paso, TX 79998-1593
A wholly owned stock subsidiary of and administrator for
The Guardian Life Insurance Company of America, New York, NY

Psychiatric Physician's Statement | Questions regarding this form? Call Toll Free 1-888-275-7473

To the Physician: Please provide answers to the questions below to support our evaluation of your patient's claim for disability benefits.

Patient's Name	File No.	Date of Birth
Ryan Fishman	81720	10-24-85

Patients Chief Complaint(s):

Date of First Visit: 4-30-21 Date of most recent visit: 9-5-21 Date of Next Visit: 8-12-21

Diagnosis(es): ICD-10 / DSM-V Code(s):

1. 309. (DSM) Adjustment Disorder with anxiety

Do you believe you have a sufficient understanding of this patient's occupation(s) and job duties to comment on their functional ability to work? Yes No

If yes, what is your understanding of this patient's occupation(s) and job duties? Pt is a practitioner
a Horney, administrator of a collection practice

Are you advising this patient to:

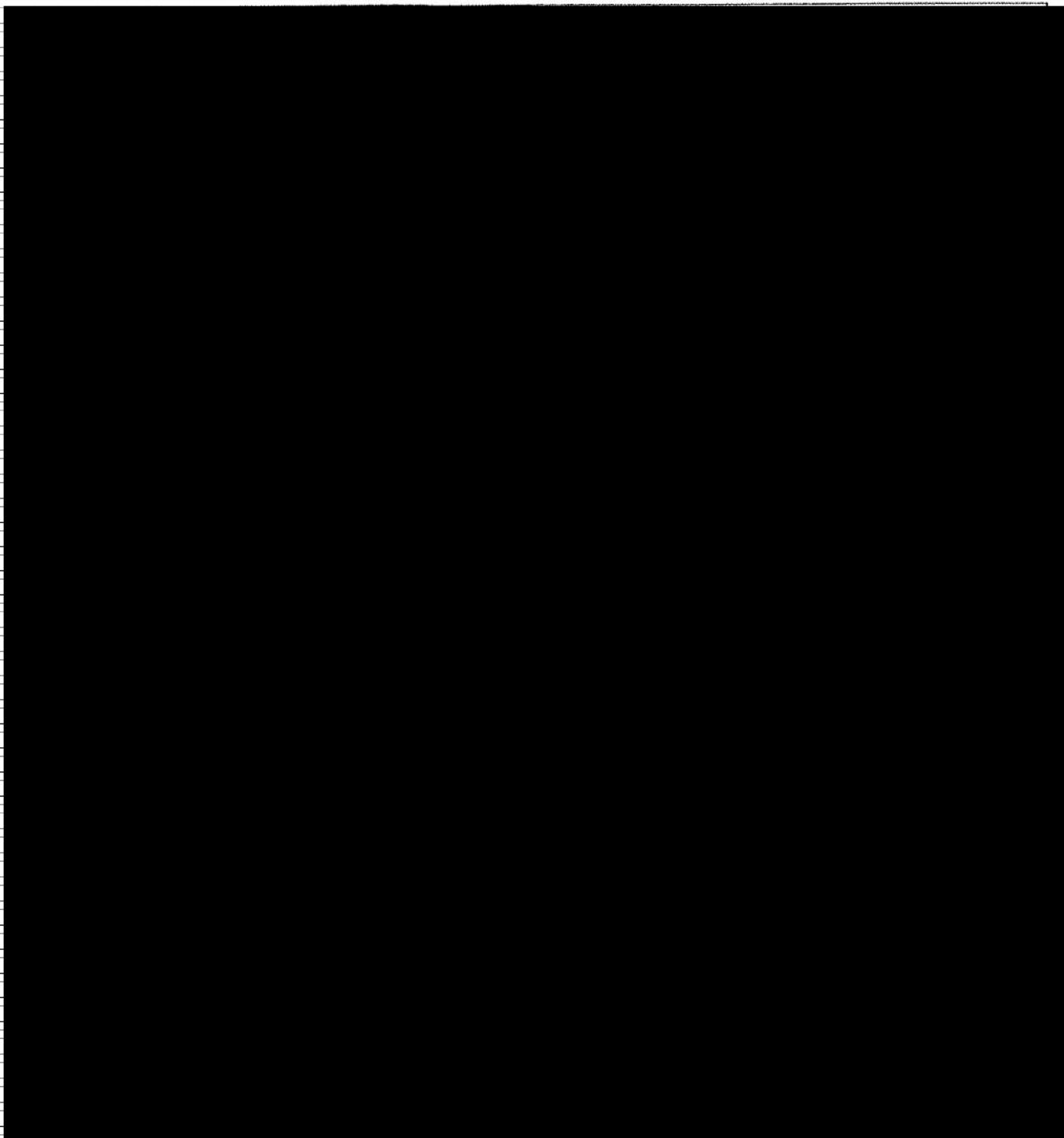
a) Restrict or limit work activities? Yes No If yes, as of what date? ____ / ____
If yes, what aspects of this patient's job duties are they restricted or limited from performing?

b) Stop working altogether? Yes No If yes, as of what date? ____ / ____
If yes, what aspects of this patient's job duties are they unable to perform?

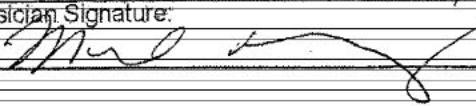
What is the patient's anticipated time frame for return to work?

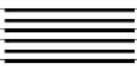
Unknown

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benefits.

Michael F Abramsky		Clinical Psychiatry
Physician Name (please print):	Medical Specialty(ies):	
Office Telephone No.: 242-644-7398	Office Fax No.: abramsckmf nous@gmail.com	
Office Address, City or Town, State or Province, Zip Code: 957 Canterbury, Birmingham, MI 48009	Date: 8-5-21	
Physician Signature: 		



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To the Physician: Please provide answers to the questions below to support our evaluation of your patient's claim for disability benefits.

Patient's Name	File No.	Date of Birth
Ryan Fishman	81720	10-24-83

Patient's Chief Complaint(s):

Date of First Visit: 9-30-21 Date of most recent visit: 9-5-21 Date of Next Visit: 8-12-21

Diagnosis(es):

ICD-10 / DSM-V Code(s):

1. 309. (DSM) Adjustment disorder with anxiety

2.

3.

Do you believe you have a sufficient understanding of this patient's occupation(s) and job duties to comment on their functional ability to work? Yes NoIf yes, what is your understanding of this patient's occupation(s) and job duties? Pt is a practitioner
a Horney, administrator of a collection practice

Are you advising this patient to:

a) Restrict or limit work activities? Yes No If yes, as of what date? 1/1/

If yes, what aspects of this patient's job duties are they restricted or limited from performing?

b) Stop working altogether? Yes No If yes, as of what date? 1/1/

If yes, what aspects of this patient's job duties are they unable to perform?

What is the patient's anticipated time frame for return to work?

Unknown

Does this patient have a history of a psychiatric condition? Yes NoDoes this patient have a history of substance abuse? Yes No

Specify current treatment plan / type of treatment (i.e., CBT, DBT, EMDR, Medication Management, IOP, Frequency of Visits, etc.):

Weekly Psychotherapy, including meditation practice
and general health monitoring; exercise, diet

Current medications (include dosage, frequency and last date of change):

Treatment goals: Resolve Anxiety, return to functions

Does the treatment plan include return to work goals? Yes No Please explain:Is this patient compliant with your recommended treatment? Yes NoHave you discussed your treatment plan and return to work goals with this patient? Yes No

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Is this patient in agreement with the treatment plan? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Test results or other rating scale score (please specify test, scale, measure used, and date): No findings	
Objective observations of this patient's behaviors, affect, mood: Mood is anxious, periods of depression. Concentration, attention significantly compromised	
Subjective complaints reported by this patient (include frequency, severity, duration): Distractible, obsessive, Frustrated, worried, dependent	
Is this patient treating with any other provider(s)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please include name and specialty:	
Are you coordinating care with this provider(s)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, last date of contact:	
How would you rate this patient's current degree of psychiatric impairment?	
<input type="checkbox"/> I do not have sufficient information to make a reasonable assessment. <input type="checkbox"/> Essentially good functioning in all areas. Occupationally and socially effective. <input checked="" type="checkbox"/> Moderate impairment in occupational functioning. Limited in performing some, but not all, occupational duties. Able to maintain meaningful interpersonal relationships. <input type="checkbox"/> Major impairment in several areas, e.g., work, family relations. Avoidant behaviors, neglects family, unable to work.	
Do you believe this patient is competent to endorse checks and direct the use of the proceeds? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, as of: 8/5/21	
Do you believe this patient is competent to execute a Power of Attorney? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, as of: 8/5/21	
Have you completed disability claim forms on behalf of this patient for other insurance carriers? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please provide the name of the company(ies):	
Are you related to this patient by blood or marriage, or are you a member of this patient's household? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are you this patient's business partner, professional partner, employer, or a person who has a financial affiliation or business interest with this patient? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Our goal is to understand the extent to which your patient is restricted or limited by the chief complaints outlined above. If we have additional questions after reviewing this form, a claim professional or clinical consultant may contact you.	
What is a convenient day and time for us to call? Tues - Friday 9-5	
What telephone number would you like us to use? 248-644-7398	
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.	
Michael F Abramsky Clinical Psychologist Physician Name (please print): Medical Specialty(ies): Office Telephone No.: 248-644-7398 Office Fax No.: abramskeymf non2@gmail.com Office Address, City or Town, State or Province, Zip Code: 954 Canterbury, Birmingham, MI 48009 Physician Signature: Date: 8-5-21	